

OFFICE OF EMERGENCY MEDICAL SERVICES**APPLICATION FOR TEMPORARY WAIVER OF EMT CERTIFICATION REQUIREMENTS**

Refer to OEMS Administrative Requirement (A/R 5-202) for further information relative to this waiver application. All information must be typed or printed legibly.

Ambulance Service Number

Ambulance Service Name

Owner or Chief Officer

Street Address or P.O. Box

Title

City/Town/State

Zip Code

Telephone

JUSTIFICATION FOR WAIVER: Explanation as to why the public convenience and necessity require such a waiver (attach any additional documentation as appropriate):

INDIVIDUAL TO BE COVERED BY THIS WAIVER: _____

STREET ADDRESS OR P.O. BOX: _____

CITY/TOWN: _____ **STATE:** _____ **ZIP:** _____

SOCIAL SECURITY NUMBER: _____

1. Has an ambulance service ever been issued a temporary waiver for this individual previously?
 _____ No _____ Yes, date _____
2. Has the individual taken any portion of the Mass. EMT Certification Exam?
 _____ No _____ Yes, date _____
3. What level will the EMT be working at while on this waiver?
 ☐ Basic ☐ Intermediate ☐ Paramedic
4. For waiver eligibility, please check and attest to the following:
 ☐ Individual is a certified EMT in another state and has applied to OEMS for a challenge examination
 State where EMT certification is current _____
 ☐ The Service's Medical Director has authorized this EMT to provide prehospital patient care for this service.
 ☐ Individual has submitted an application for Massachusetts EMT certification examination.

AMBULANCE SERVICE:

I request this waiver on behalf of the ambulance service and I fully understand the requirements and conditions of such a waiver. I attest to the fact that a) the service is holding a position for a specifically named out-of-state certified EMT for work in Massachusetts at the certification level of his or her out-of-state certification, and b) the service accepts full responsibility for orienting and overseeing/monitoring/evaluating his work for the duration of the waiver period. I understand that this waiver is valid for no longer than one year, and is not renewable.

Signature _____

Date _____

INDIVIDUAL TO BE COVERED BY THIS WAIVER:

I concur with this request by the ambulance service and I fully understand the requirements and conditions of such a waiver.

Signature _____

Date _____

Attach current, legible copies of driver's license, copy of EMT certification/license, and copy of both sides of CPR card, (American Heart Assoc. level-C provider or Red Cross professional rescuer, or National Safety Council "Health Care Provider") For EMT-Paramedics attach copy of both sides of ACLS card.

For office use only:

Effective Date

Expiration Date